

**North Carolina Department of Health and Human Services**  
**Division of Public Health • Epidemiology Section**  
**Communicable Disease Branch**

**ATTENTION HEALTH CARE PROVIDERS:**

Please report relevant clinical findings about this disease event to the local health department.

**VIBRIO INFECTION, VULNIFICUS**  
**Confidential Communicable Disease Report—Part 2**  
**NC DISEASE CODE: 54**

**ATTENTION Local Health Department Staff: There is no Part 2 Wizard for this disease.**  
**Enter all information from this form into the NC EDSS question packages.**

If sending this form to the Health Care Provider, remember to attach a cover letter from your agency indicating the part(s) of the form the provider should complete.

Patient's Last Name	First	Middle	Suffix	Maiden/Other	Alias	Birthdate (mm/dd/yyyy) / /
						SSN



**NC EDSS  
LAB RESULTS**

Verify if lab results for this event are in NC EDSS. If not present, enter results.

Specimen Date	Specimen #	Specimen Source	Type of Test	Test Result(s)	Description (comments)	Result Date	Lab Name—City/State
/ /						/ /	
/ /						/ /	
/ /						/ /	

**CLINICAL FINDINGS**

Is/was patient symptomatic for this disease? ☐ Y ☐ N ☐ U

If yes, symptom onset date (mm/dd/yyyy): / /

Fever ☐ Y ☐ N ☐ U

☐ Yes, subjective ☐ No

☐ Yes, measured ☐ Unknown

Highest measured temperature \_\_\_\_\_

Unit: ☐ Fahrenheit ☐ Centigrade

Fever onset date (mm/dd/yyyy): \_\_\_\_\_

Shock ☐ Y ☐ N ☐ U

Was systolic BP <90mm Hg ☐ Y ☐ N ☐ U

Was shock septic? ☐ Y ☐ N ☐ U

Headache ☐ Y ☐ N ☐ U

Muscle aches / pains (myalgias) ☐ Y ☐ N ☐ U

Skin rash ☐ Y ☐ N ☐ U

Skin lesions ☐ Y ☐ N ☐ U

Please describe (check all that apply)

☐ Papule ☐ Ulcer ☐ Bullae

Cellulitis ☐ Y ☐ N ☐ U

Nausea ☐ Y ☐ N ☐ U

Vomiting ☐ Y ☐ N ☐ U

Abdominal pain or cramps ☐ Y ☐ N ☐ U

Diarrhea ☐ Y ☐ N ☐ U

Describe (select all that apply)

☐ Bloody ☐ Non-bloody

☐ Watery ☐ Other

Maximum number of stools in a 24-hour period: \_\_\_\_\_

Other symptoms, signs, clinical findings, or complications consistent with this illness ☐ Y ☐ N ☐ U

Please specify:

**PREDISPOSING CONDITIONS**

HIV/AIDS ☐ Y ☐ N ☐ U

Immunosuppressive conditions (other than HIV/AIDS) ☐ Y ☐ N ☐ U

Diabetes ☐ Y ☐ N ☐ U

Is the patient on insulin? ☐ Y ☐ N ☐ U

Hematologic disorder ☐ Y ☐ N ☐ U

Sickle cell ☐ Y ☐ N ☐ U

Other hematologic disorder(s) ☐ Y ☐ N ☐ U

Malignancy ☐ Y ☐ N ☐ U

Cardiovascular/heart disease ☐ Y ☐ N ☐ U

Gastrointestinal disease ☐ Y ☐ N ☐ U

☐ Gastric surgery or gastrectomy

☐ Peptic ulcer

☐ Other GI disease (GERD, etc.)

Specify:

Liver disease ☐ Y ☐ N ☐ U

☐ Chronic liver disease or cirrhosis

☐ Liver failure

☐ Other liver disease(s)

Kidney disease ☐ Y ☐ N ☐ U

☐ Chronic renal failure

☐ Acute renal failure

☐ Other kidney disease(s)

Injury/Wound/Break in skin ☐ Y ☐ N ☐ U

Anatomic site \_\_\_\_\_

Other condition potentially affecting skin integrity? ☐ Y ☐ N ☐ U

Specify condition(s) \_\_\_\_\_

Receiving treatment or taking any medications ☐ Y ☐ N ☐ U

☐ Antacids

☐ Antibiotics

☐ Chemotherapy

☐ H2 blockers, proton pump or ulcer medication

☐ Immunosuppressive therapy, including anti-rejection therapy

☐ Radiotherapy

☐ Systemic steroids/corticosteroids, including steroids taken by mouth or injection

**CLINICAL OUTCOMES**

Discharge/Final diagnosis: \_\_\_\_\_

Survived? ☐ Y ☐ N ☐ U

Died? ☐ Y ☐ N ☐ U

Died from this illness? ☐ Y ☐ N ☐ U

Date of death (mm/dd/yyyy): / /

Autopsy performed? ☐ Y ☐ N ☐ U

Patient autopsied in NC? ☐ Y ☐ N ☐ U

County of autopsy: \_\_\_\_\_

Autopsied outside NC, specify where: \_\_\_\_\_

Source of death information (select all that apply):

☐ Death certificate

☐ Autopsy report final conclusions

☐ Hospital/discharge physician summary

☐ Other

**HOSPITALIZATION INFORMATION**

Was patient hospitalized for this illness >24 hours? ☐ Y ☐ N ☐ U

Hospital name: \_\_\_\_\_

City, State: \_\_\_\_\_

Hospital contact name: \_\_\_\_\_

Telephone: (\_\_\_\_) \_\_\_\_\_

Admit date (mm/dd/yyyy): / /

Discharge date (mm/dd/yyyy): / /

<b>Patient's Last Name</b>	First	Middle	Maiden/Other	Suffix	Alias	<b>Birthdate</b> (mm/dd/yyyy) / /
						<b>SSN</b> / /

### TREATMENT

Did the patient take an antibiotic as treatment for this illness? ..... ☐ Y ☐ N ☐ U  
Specify antibiotic name \_\_\_\_\_

### TRAVEL/IMMIGRATION

The patient is:  
☐ Resident of NC  
☐ Resident of another state or US territory  
☐ Foreign Visitor  
☐ Refugee  
☐ Recent Immigrant  
☐ Foreign Adoptee  
☐ None of the above

Did patient travel during the 3 days prior to onset of symptoms? ..... ☐ Y ☐ N ☐ U  
List travel dates and destinations:  
From \_\_\_\_/\_\_\_\_/\_\_\_\_ to \_\_\_\_/\_\_\_\_/\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Does patient know anyone else with similar symptom(s) who had the same or similar travel history? ..... ☐ Y ☐ N ☐ U  
List persons and contact information:  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Additional travel/residency information:

### WATER EXPOSURE

During the 3 days prior to onset of symptoms, did the patient have recreational, occupational, or other exposure to estuarine or marine water (brackish or salt water sound, estuary, ocean)? ..... ☐ Y ☐ N ☐ U  
On (mm/dd/yyyy) \_\_\_\_\_  
  
Until (mm/dd/yyyy) \_\_\_\_\_

Frequency  
☐ Once  
☐ Multiple times within this time period  
☐ Daily

Route of exposure (agent entry) for recreational exposure (check all that apply):  
☐ Accidental ingestion  
☐ Intentional ingestion  
☐ Skin contact  
☐ Inhalation  
☐ Other  
☐ Unknown

Water source(s) / setting(s) (select all sources and settings that apply):  
☐ River, stream (brackish only)  
☐ Estuary / tidal area (brackish / salty water)  
☐ Ocean  
☐ Pool (salt water or brackish only)  
☐ Whirlpool / spa pool (salt water or brackish only)  
☐ Other  
☐ Unknown

### FOOD EXPOSURE

During the 3 days prior to onset of symptoms, did the patient do any of the following:  
Did the patient drink any bottled water? ..... ☐ Y ☐ N ☐ U  
Specify type/brand \_\_\_\_\_

Describe the source of drinking water used in the patient's home (check all that apply):  
☐ Bottled water supplied by a company  
☐ Bottled water purchased from a grocery store  
☐ Municipal supply (city water)  
☐ Well water

Does the patient have a water softener or water filter installed inside the house to treat their water? ..... ☐ Y ☐ N ☐ U

During the 3 days prior to onset of symptoms, did the patient do any of the following:  
Handle / eat shellfish (i.e. clams, crab, lobster, mussels, oysters, shrimp, crawfish, other shellfish)? ..... ☐ Y ☐ N ☐ U  
Handle / eat clams? ..... ☐ Y ☐ N ☐ U

Obtained from \_\_\_\_\_  
Name \_\_\_\_\_  
Location \_\_\_\_\_  
Phone # of establishment \_\_\_\_\_  
Brand name (if applicable) \_\_\_\_\_  
Preparation method(s) \_\_\_\_\_  
☐ Unknown  
Was this food undercooked or raw? .. ☐ Y ☐ N ☐ U  
Handled/consumed on (mm/dd/yyyy) \_\_\_\_\_  
Until (mm/dd/yyyy) \_\_\_\_\_  
Frequency:  
☐ Once  
☐ Multiple times within this time period  
☐ Daily

Time consumed \_\_\_\_\_ ☐ AM ☐ PM  
Amount consumed \_\_\_\_\_  
Was this seafood the most likely source of illness? ..... ☐ Y ☐ N ☐ U  
Was seafood imported from another country? ..... ☐ Y ☐ N ☐ U

Exporting country \_\_\_\_\_  
Were clams eaten? ..... ☐ Y ☐ N ☐ U  
How were they distributed to retail outlet?  
☐ Shell stock (sold in shell)  
☐ Shucked  
☐ Unknown  
☐ Other

Date restaurant/outlet received seafood \_\_\_\_\_  
Was restaurant/retail outlet inspected as part of investigation? ..... ☐ Y ☐ N ☐ U  
Are shipping tags available? ..... ☐ Y ☐ N ☐ U  
Shippers who handled suspect seafood (include certification numbers if on tags) \_\_\_\_\_  
\_\_\_\_\_

Source of seafood \_\_\_\_\_  
Harvest date (mm/dd/yyyy) \_\_\_\_\_  
Harvest site status:  
☐ Approved ☐ Conditional  
☐ Prohibited ☐ Other

Maximum ambient temperature \_\_\_\_\_ ☐ °F ☐ °C  
Date measured (mm/dd/yyyy) \_\_\_\_\_  
Surface water temperature \_\_\_\_\_ ☐ °F ☐ °C  
Date measured (mm/dd/yyyy) \_\_\_\_\_  
Salinity (ppt) \_\_\_\_\_  
Date measured (mm/dd/yyyy) \_\_\_\_\_  
Total rainfall (inches in previous 5 days) \_\_\_\_\_  
Date measured (mm/dd/yyyy) \_\_\_\_\_

Fecal coliform count \_\_\_\_\_  
Date measured (mm/dd/yyyy) \_\_\_\_\_  
Was there evidence of cross-contamination, or improper storage or holding temperatures at any point? ..... ☐ Y ☐ N ☐ U  
Specify deficiencies \_\_\_\_\_  
\_\_\_\_\_

Handle / eat finfish (i.e. Tuna, Mackerel, Skip Jack, Amber Jack, Bonito, mahi-mahi / dorado, Blue fish, Salmon, Puffer fish, Porcupine fish, Ocean sunfish, sushi)? ..... ☐ Y ☐ N ☐ U

Type of fish \_\_\_\_\_  
Obtained from \_\_\_\_\_  
Name \_\_\_\_\_  
Location \_\_\_\_\_  
Phone # of establishment \_\_\_\_\_  
Brand name (if applicable) \_\_\_\_\_  
Preparation method(s) \_\_\_\_\_  
☐ Unknown  
Was this food undercooked or raw? .. ☐ Y ☐ N ☐ U  
Handled/consumed on (mm/dd/yyyy) \_\_\_\_\_  
Until (mm/dd/yyyy) \_\_\_\_\_  
Frequency:  
☐ Once  
☐ Multiple times within this time period  
☐ Daily  
Time consumed \_\_\_\_\_ ☐ AM ☐ PM  
Amount consumed \_\_\_\_\_  
Was this seafood the most likely source of illness? ..... ☐ Y ☐ N ☐ U

Notes:

[illegible]

## **Vibrio vulnificus infection**

### **2007 Case Definition (North Carolina)**

#### **Clinical description**

An infection of variable severity characterized by diarrhea and vomiting, primary septicemia, or wound infections. Asymptomatic infections may occur, and the organism may cause extraintestinal infections.

#### **Laboratory criteria for diagnosis**

Isolation of *Vibrio vulnificus* from a clinical specimen.\*

#### **Case classification**

*Confirmed:* A case that meets the laboratory criteria for diagnosis. Note that species identification and, if applicable, serotype designation should be reported.

*Probable:* A clinically-compatible symptomatic case that is epidemiologically linked to a confirmed case.

#### **Comment**

\*Infections due to toxigenic *Vibrio cholerae* O1 or O139 are reportable as Cholera.

\**Vibrio* infections due to *Vibrio spp.* other than *Vibrio cholerae* O1 or O139 or *Vibrio vulnificus* are reportable as *Vibrio* infection, other.